1994

Doxey Hatch Medical Center, Amber Peterson v. Utah Department of Health : Brief of Appellant

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

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DOXEY-HATCH MEDICAL CENTER/ AMBER PETERSON,	)	
Petitioner-Appellant,	)	COURT OF APPEALS
v.	)	NO. 940543-CA
UTAH DEPARTMENT OF HEALTH, Division of Health Care Financing,	)	
Respondent-Appellee.	)	

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BRIEF OF PETITIONER-APPELLANT DOXEY-HATCH MEDICAL CENTER/AMBER PETERSON

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PETITION FOR REVIEW FROM THE FINAL AGENCY ORDER OF THE UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, JOANN GALLEGOS, DIRECTOR

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ARGUMENT PRIORITY CLASSIFICATION PER UTAH R. APP. P.29(b):14

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BRIEF OF PETITIONER-APPELLANT DOXEY-HATCH MEDICAL CENTER/AMBER PETERSON

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JURISDICTION OF THE COURT OF APPEALS

This case is an appeal from the Final Agency Order of the Division of Health Care Financing (DHCF) of the Utah Department of Health, denying Appellant Doxey-Hatch Medical Center ("Doxey-Hatch") Medicaid reimbursement for skilled nursing home care rendered to Amber Peterson ("Amber") for the period September 6, 1993, through November 30, 1993. Consequently, this Court has jurisdiction under Utah Code Ann. Section 63-46b-16.

ISSUES PRESENTED FOR REVIEW AND STANDARD OF REVIEW

The issues are whether Utah Administrative Rule R455 (the Bureau of Facility Review Preadmission and Continued Stay Policy and Procedures Manual) governing this case is reasonable as written (Transcript of Proceedings ("T"), 6) and whether Doxey-Hatch has

been substantially prejudiced by an agency (DHCF) action that is an abuse of discretion, contrary to the agency's prior practice (T. 33), or otherwise arbitrary and capricious (T. 6, 7).

The standard of review is one of reasonableness and rationality. South Davis Hospital, Inc./Romero v. Department of Health, Division of Health Care Financing, 869 P.2d 979 (Utah C.A. 1994), hereinafter sometimes referred to as "the Romero case." Kent v. Department of Employment Security, 860 P.2d 984 (Utah App. 1993). Norton Int'l, Inc. v. Utah State Tax Comm'n, 832 p.2 1294 (Utah 1992). Since this case involves interpretation of state and federal statutes, rules and regulations governing the Medicaid program, DHCF's decision is not entitled to any particular deference but must be reviewed for correctness. Bleazard v. Utah Department of Health, Division of Health Care Financing, 861 P.2d 1048 (Utah App. 1993); see also Allen v. Department of Health, 850 P.2d 1267 (Utah 1993). Utah Code Ann. §63-46(b)-16(4)(b) and (h) provides the statutory basis for the standard of review.

DETERMINATIVE STATUTES AND RULES

The following statutes and rules, all of which are included verbatim in the Addendum, are determinative of this matter:

Utah Code Ann. Section 26-18-2.3

Utah Code Ann. Section 26-18-3

Utah Code Ann. Section 63-46(b)-16

Utah Admin. Rule R455 (now renumbered as R414).

STATEMENT OF THE CASE

A. NATURE OF CASE

This was a proceeding brought by Petitioner-Appellant before the DHCF for Medicaid reimbursement for skilled nursing home care for Amber for the period of September 6, 1993 through November 30, 1993. Reimbursement had been disallowed because Appellant failed, for reasons hereinafter set forth, to submit a new preadmission screening form to DHCF when Amber was readmitted to Doxey-Hatch after a six-day stay at Primary Children's Medical Center. The necessary Form 10A, which DHCF maintains is required by DHCF rules when a patient is returned to a care facility after a hospital stay of more than 3 days, was not filed until December 1, 1993. The amount at issue is $18,301.66.

B. COURSE OF PROCEEDINGS

In December, 1993, DHCF denied an application by Appellant for reimbursement for medical care and services provided to Amber. Following said denial, Appellant filed a Request for Hearing/Agency Action. A hearing at DHCF was held on July 20, 1994. The Administrative Law Judge entered a Recommended Decision to deny reimbursement on August 19, 1994 which was approved by the Final Agency Order on August 23, 1994. Appellant filed its Petition for Writ of Review with this Court on or about September 20, 1994.

C. DISPOSITION BY DHCF

The Final Agency Order adopted the Recommended Decision denying Appellant Medicaid reimbursement for Amber's nursing home care for the period of September 6, 1993 through November 30, 1993.

D. FACTS SUPPORTING RECOMMENDED DECISION AND FINAL AGENCY ACTION

1. Utah Admin. Rule R455-9-6-G[1] states that preadmission authorization is not required for a hospital admission when the applicant returns to the original nursing care facility within less than three days. Otherwise, preadmission procedures must be followed. Utah Admin. R455-9-10.

2. Amber, a patient at Doxey-Hatch, was taken to Primary Children's Medical Center on September 1, 1993 and returned to Doxey-Hatch on September 6, 1993 (T.8).

3. Doxey-Hatch failed to complete a preadmission transmittal (Form 10A) for Amber's return to Doxey-Hatch on September 6, 1993 until December 1, 1993 (T. 72).

4. The Bureau of Facility Review, Department of Health, was unaware that Amber's September hospitalization exceeded three days until November, 1993 when Doxey-Hatch requested its assistance in locating Form 10A which, of course, had not been filed prior to that inquiry (T. 71).

5. A periodic review of Amber's condition was held in October 1993 by Medicaid personnel with Doxey-Hatch personnel but no mention was made that the hospital stay exceeded three days (T. 69).

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[1]Note that R455 has been renumbered as R414 but the old designation is used throughout this brief because Respondent's Exhibit 1, which is a complete copy of the Rule, uses the old number. Also, this is how the rule was referred to at the hearing.

E. STATEMENT OF ADDITIONAL RELEVANT FACTS SUPPORTING PETITIONER/APPELLANT'S POSITION THAT THE FINAL AGENCY ACTION IS UNREASONABLE, IRRATIONAL, CONTRARY TO A RULE OF THE AGENCY, CONTRARY TO PRIOR AGENCY ACTIONS, AND ARBITRARY AND CAPRICIOUS

1. Medicaid is a state and federally funded, state administered program (42 U.S.C. §1396(a)) to provide medical care to persons that meet certain financial and medical eligibility criteria. Medicaid in Utah is administered by Department of Health, Division of Health Care Financing. Utah Code Ann. §§26-18-2.3 & 26-18-3. There are about 5,000 Medicaid recipients in Utah (T. 24, 47). Pursuant to federal mandates (42 U.S.C. §1396(a)) and the Utah Medical Assistance Act, Utah Code Ann. §26-18-1 et seq., DHCF has adopted Administrative Rule 455 referred to as Part A (Respondent's Exh. No. 1) governing "Nursing Facility Preadmission/Continued Stay Review and Level of Care Criteria." One of the provisions, R455-9-6-G, states that "Preadmission authorization will not be required for a hospital admission when the applicant/recipient returns to the original nursing care facility within less than three consecutive days ... of admission to the hospital." [Emphasis added.]

2. Doxey-Hatch offers a full range of medical services (T. 93, 94). Its patient population is from 115 to 130 and it averages 80 to 90 admissions and discharges per month (T. 129). At any one time, seventy to eighty patients are Medicaid patients (T.129).

3. Amber is a nine year old long-term patient at Doxey-Hatch as a result of a near drowning that occurred at the Great Salt Lake

in 1991 when Amber was six years old (T. 63, 64). The original preadmission screening was done on November 22, 1991 (T. 64). A copy of that Form 55 (formerly and still more commonly referred to as "Form 10A") is Petitioner's Exhibit No. 5.

4. Amber requires a very high degree of care and Doxey-Hatch is reimbursed at additional premium rates over and above the normal rate for nursing home care because of the extra care required (T. 25).

5. Amber has had to go to the hospital on several occasions for medical treatment, after which she has always been returned to Doxey-Hatch. In each case, a new Form 10A was either not required or was timely submitted to Medicaid (T. 64, 67, 69).

6. On the occasion at issue, Amber was taken to the hospital on September 1, 1993 and returned to Doxey-Hatch on September 6, 1993 (T. 8). Amber's care plan or need for intensive skill care did not change after her return (T. 26, 29). A new Form 10A was not submitted immediately upon her return from the hospital (T. 72).

7. September 6, 1993 happened to be Labor Day. The normal staff member of Doxey-Hatch who should have prepared Form 10A was not at work on the day that Amber was returned to the facility (T.112).

8. Primary Children's Medical Center did not notify DHCF that Amber had been released back to Doxey-Hatch as is usually done when a patient is returned to a nursing facility (T. 95, 95). Had the hospital done so, Doxey-Hatch would have been notified and

would, in turn, have generated a Form 10A (T. 96). The usual procedure was presumably not followed by the hospital because it was a holiday when Amber was released back to Doxey-Hatch (T. 96).

9. Steve Booth, Doxey-Hatch's Assistant Director of Nursing, who would have been responsible for making sure that the appropriate prescreening was completed upon Amber's return, was on vacation when Amber was returned from the hospital (T. 112). Booth terminated employment with Doxey-Hatch before the omission was discovered (T. 131). Lyla Littlefield, the Director of Nursing, was ill during September, 1993 and this may have also contributed to the omission (T. 113).

10. Upon return from the hospital, the appropriate form for prescreening should have been sent by the nursing staff to the billing office (T. 126). The billing office should have realized that the appropriate form for Amber had not been submitted (T.126). However, the person in charge of billing Medicaid, Shannon Duncan, was at that time embezzling funds from Doxey-Hatch and not performing her job as she should have been (T. 94). She was subsequently terminated from her employment and formally charged with embezzlement (T. 94, 105). She has been subject to criminal penalties and an order of reimbursement for embezzled funds (T.105).

11. All of the Medicaid patients require 30, 90, and 180 day reviews (T. 21). Not every patient is reviewed monthly but there are a significant number of reviews ongoing at various times (T. 65). In October, 1993, Sherry Burrell, one of the nurse

reviewers for the Department of Health, called Steve Booth of Doxey-Hatch to tell him which patients were due for a review, which included Amber, and that the review would be done on October 25, 1993 (T. 68).

12. The periodic review for Amber was conducted by Sherry Burrell for the DHCF and by Steve Booth for Doxey-Hatch on October 25, 1993 (T. 68). Ms. Burrell testified that at that time no mention was made by Mr. Booth of the fact that Amber had been to the hospital for a six-day stay (T. 69). However, there is a note on the October 25, 1993 review form filled out by Ms. Burrell (Respondent's Exhibit No. 3), that Amber had been to the hospital on September 6, 1993 to have a gastro-intestinal tube installed (T. 76). Ms. Burrell did not inquire as to the length of Amber's hospital stay (T. 79). She testified that this was not unusual because this procedure usually requires a stay of less than three days (T. 79).

13. A new Form 10A was finally submitted effective as of December 1, 1993 (T. 72). Doxey-Hatch has not been paid for Amber's care from September 6, 1993 through November 30, 1993, which charges total $18,301.66. (Petitioner's Exhibit No. 6).

14. The need for a new Form 10A was ultimately discovered as a result of the billings by Doxey-Hatch for September, 1993, which were submitted on October 1, 1993, and the "Remittance Statement" from Medicaid, dated as of December 10, 1993, notifying Doxey-Hatch that payment would not be made for Amber for September 6 through

November 30, 1993. By that time, the services for October and November had also been rendered to Amber (T. 102).

15. Doxey-Hatch has only had a few minor occasions when the Form 10A was not submitted on time. Each instance involved only a day or two and was written off (T. 129, 131). However, in this case, Doxey-Hatch is looking at lost revenue for eighty-five days of unpaid services rendered to a Medicaid patient who was clearly financially and medically eligible for payment had the proper paperwork been submitted (T. 25).

16. To alleviate problems of nonpayment of services due to late filing of Form 10A by nursing home care providers, and at the request of the Utah Health Care Association, the Department of Health has adopted a new policy, effective April 1, 1994, that allows each nursing care facility to have up to 30 patient days of care that can be paid even though one or more Form 10As have not been timely submitted (T. 37, Respondent's Exh. 4).

17. Carolyn Reese, manager of the Patient Assessment Section of the DHCF, testified that there have been two occasions where exceptions to the rules have been granted due to extenuating circumstances but that she did not feel that this was a case warranting an exception to the rules (T. 33-36). These cases will be discussed later in this Brief at pages 19 and 20.

18. Carolyn Reese admitted that the State would not be out any Medicaid funds in this case if reimbursement were allowed because Amber was clearly qualified for nursing home care and there

has been no change in the level of care required. The only reason for nonpayment was the failure to submit Form 10A (T. 87).

19. As demonstrated by Petitioner's Exhibits 3 and 4 (Notice of Decision dated October 15, 1993 notifying Amber that she is still eligible for nursing home care and Medicaid Identification Cards for October, November and December, 1993), the Department of Human Resources and the Utah Department of Health, both State agencies, knew that Amber was a Medicaid patient and that she was at Doxey-Hatch (all of these documents were addressed to Amber at Doxey-Hatch). Significantly, DHCF is a division of the Department of Health. Furthermore, Sherry Burrell of DHCF called Steve Booth to set up Amber's review in October, 1993 (T. 68).

SUMMARY OF ARGUMENT

The final agency Order should be reversed and Medicaid should pay Appellant's claim for the following reasons:

1. This is a very fact-specific case and when all of the facts are taken into consideration, it is clear that DHCF acted unreasonably and irrationally in denying Medicaid reimbursement.

2. The relevant provisions of the applicable rules are unreasonable because they require a new preadmission screening on the return of a patient to a nursing home facility after more than a three-day hospital stay when federal rules do not require that state rules contain that requirement. This rule is especially unreasonable considering other rules that provide that there can be no exceptions to this policy, that the facility cannot bill the patient or anyone else for the services, and, further, that the

rules provide for an appeal procedure when payment is denied due to the failure to follow the procedures but, in point of fact, there is no appeal remedy allowed because no exceptions to the rule are allowed, a fact well demonstrated by this case.

3. The decision to deny payment to Appellant is inconsistent with other cases in which payment was allowed by DHCF.

4. A careful reading and examination of the rule demonstrates that it is worded in such a way that it does not really require a preadmission screening on the return to the nursing home after a hospital stay of more than three days. In effect, DHCF is misinterpreting its own rules.

ARGUMENT

APPELLANT SHOULD BE REIMBURSED FOR AMBER PETERSON'S NURSING HOME CARE FROM SEPTEMBER 6, 1993 THROUGH NOVEMBER 30, 1993 NOTWITHSTANDING THAT APPELLANT DID NOT COMPLETE THE NECESSARY FORM 10A UNTIL DECEMBER 1, 1993

A. The Facts and Circumstances of the Case Show that DHCF Acted Unreasonably and Irrationally in Denying Reimbursement.

This Court, in the somewhat similar case of South Davis Hospital, Inc./Romero v. Department of Health, Division of Health Care Financing, supra, held that the proper standard of review is whether DHCF acted reasonably and rationally in denying Medicaid reimbursement when Form A was not timely submitted. In that case, the patient, Romero, had never been in the Medicaid system prior to the time period in question. DHCF didn't know of her medical or financial eligibility for Medicaid until the first Form 10A was ultimately filed some five months after her private insurance

coverage was exhausted. The case at hand is clearly distinguishable from Romero on its facts. In Romero, the court determined that the agency action was reasonable because of the purpose of the preadmission screening requirement, which was to "safeguard against unnecessary or inappropriate use of medical services, excessive payments, and unnecessary or in appropriate hospital admissions or lengths of stay." (Supra, 981.) The court also discussed the fact that the preadmission screening rules were promulgated to meet federal regulations and that without these rules Utah could lose Medicaid funds. (Supra, 982.) Furthermore, Romero had never had the required physician certification prior to the time period involved. However, in this case, Amber had been certified for admission, had been recertified during various periodic reviews before her September 1 to September 6, 1993 hospitalization, and was again recertified during the October, 1993, interview. Furthermore, as discussed on pages 15 and 18 in more detail, federal law does not require a new preadmission screening when a patient returns to the nursing care facility after a hospital stay. Thus, all of the concerns expressed by the court in Romero do not exist in this case.

Doxey-Hatch acknowledges that a new Form 10A was not filed when Amber returned from the hospital on September 6, 1993. However, as shown by the above facts, there were extenuating circumstances as to why the Form 10A was not submitted more timely. These included the following:

1. This was not a new admission as in the South Davis Community Hospital/Romero case, supra, but a readmission after a short hospital stay.

2. Steve Booth, the Assistant Director of Nursing for Doxey-Hatch, who should have completed Form 10A, was on vacation when Amber returned to the facility.

3. Primary Children's Medical Center, which would have normally informed Medicaid of Amber's return to Doxey-Hatch, failed to do so because it was Labor Day.

4. Shannon Duncan, the employee in the billing office who had the responsibility for seeing that the Form 10A was submitted to DHCF and who should have noticed that there was no new Form 10A, was not doing her job and was, in fact, embezzling funds from the facility during this critical period of time.

5. Lyla Littlefield, the Director of Nursing, was ill during the month of September when Amber was returned to the hospital, which may have contributed to the oversight.

6. Due to the turn around time for billing and then being notified by Medicaid as to which patients were not being paid for, there was a delay in Doxey-Hatch discovering the oversight for about two months (from sometime in October when the September billings went to Medicaid until December 10, 1993, when they received the document showing that Amber was not being paid for September 6 through November 30), during which time Doxey-Hatch continued to provide care.

Thus, even though Doxey-Hatch erred in not getting the Form 10A in on time, there are understandable reasons why this happened. It was not due to incompetence or lack of a willingness to follow proper procedures. Indeed, as shown later, Doxey-Hatch had always been very conscientious about complying with the rules.

As the above facts show, Medicaid pays for 5,000 patients in Utah health care facilities. This is a total of about 1,825,000 patient days per year. Doxey-Hatch has 70 to 80 Medicaid patients at any one time and therefore the number of Medicaid patient days per year would be somewhere between 25,550 and 29,200. The total number of days for which Doxey-Hatch is seeking to be paid is only 85 days, which is only about .000465% of the total Medicaid days paid by the state for 1993 and is about .333% of Doxey-Hatch's Medicaid days for 1993.

DHCF has apparently allowed only three exceptions in the last five years to the Form 10A requirement, which on its face has to be unreasonable. Assuming each exception was the equivalent of one patient day (which isn't exactly the case as explained below), this is only three patient days out of a total of 9,125,000 Medicaid patient days over the last five years. It is clearly unreasonable and irrational for anyone to think that there will not be occasional slip-ups or oversights in the paperwork when there are this many patients and patient days involved in the Utah Medicaid system. The fact that Doxey-Hatch has made only a few mistakes in the past, and those involving only a day or two at a time, shows that Doxey-Hatch is very conscientious and careful about complying

with Medicaid requirements for reimbursement. If Medicaid reimburses Doxey-Hatch for the eighty-five days at issue, it will not be out any funds that wouldn't have been expended anyway if the Form 10A had been properly completed. Additionally, there is absolutely no dispute that Amber was at all times qualified for Medicaid and that the rate of reimbursement to Doxey-Hatch did not change after she returned from the hospital. DHCF knew that Amber was a very long-term patient at Doxey-Hatch. A patient review was done by DHCF on October 25, 1993, so DHCF certainly knew that Amber was at Doxey-Hatch and qualified for Medicaid.

As stated, the strict application of the rules requiring Form 10A prior to the rendering of services after readmission following a hospital stay is clearly unreasonable. This has been acknowledged by DHCF itself by the adoption of the new provision in Rule 414 that allow each facility 30 days grace per year where oversights can be corrected and paid. These new provisions in Rule 414 are the direct result of DHCF heeding the complaints of the Utah Health Care Association that R455-9 is too strict. Significantly, there is no requirement in federal law for new admission screening upon return to a facility from a hospital (see CCH Medicare and Medicaid Guide, ¶ 14,545 attached hereto).

As stated above, this case is significantly different from the case of South Davis Community Hospital, Inc./Romero v. Dept. of Health, Division of Health Care Financing, supra. In that case, Romero had never been in the Medicaid system previous to the submission of the late Form 10A and, significantly, South Davis had

not provided Romero with care at an acute level, the level of care for which reimbursement was sought. In Amber's case, she had been in the system for almost three (3) years, Medicaid had always made reimbursement for her care, Doxey-Hatch provided the level of care required, Medicaid knew that Amber was at Doxey-Hatch, and her treatment plan or level of care did not change after she was readmitted on September 6, 1993.

For the foregoing reasons, Appellant believes that DHCF's action in denying reimbursement is an abuse of discretion and otherwise arbitrary and capricious under Utah Code Ann. 63-46(b)-16(4)(h)(i) and (iv).

B. The Pertinent Provisions of Utah Administrative Rule 455 are Unreasonable.

Utah Administrative Rule 455, the Bureau of Facility Review, Preadmission and Continued Stay Review, Policy and Procedures Manual (sometimes referred to as "Part A") sets forth the rules for nursing home reimbursement. Rule 455-9-1 sets forth the purpose for preadmission and continued stay review. That rule states that the purpose is to (1) identify the medical needs of applicants or recipients who are patients of nursing care facilities; (2) to assure quality of life while guarding against over or underutilization of services and costs; (3) to insure that verification for acute care is given prior to placement; and (4) to insure that persons with mental retardation/related conditions are assessed for their need for active treatment services specific to the diagnoses. This rule is in satisfaction of the federal

Medicaid requirements set forth in 42 U.S.C. §1396(a). In Amber's case, all of these concerns had previously been addressed and satisfied.

In accordance with the stated purpose, the State has adopted policies and procedures for insuring that these purposes are met. Preadmission assessment evaluation is entirely proper and justified. However, in the case at hand, because of the facts, the strict application of these policies and procedures in the case of a readmission following a hospital stay lead to inequities and unjust results.

Rule 455-9-6 sets forth the requirements for submitting the proper documentation for Medicaid reimbursement. Paragraph G states that no preadmission authorization is required if a hospital stay is for less than three (3) consecutive days. Other than that, a new Form 10A is required. No exceptions or leeway for mistakes is provided in the rules. In fact, paragraph T of that rule provides that no payment will be made for care or services rendered prior to the receipt of a valid Form 10A and that "there will be no exceptions to this policy." (See subparagraph 2 of paragraph T.) Subparagraph 3 of paragraph T states specifically that if a provider chooses not to follow this policy the provider will assume all liability for expenses for the care of the patient. The word "chooses" implies some willful action and not mere oversight, as in this case. It also states that the provider will not bill the patient or other responsible party for the care/service not reimbursed by Medicaid due to the provider's failure to follow the

policy and procedures. This is true in spite of the fact that there is no leeway given for an honest mistake.

Paragraph GG of Rule 455-9-6 provides as follows:

> The provider may not appeal a preadmission or continued stay determination; but in accordance with Bureau or Facility Review, Policy and Procedures Manual may appeal a decision denying Medicaid reimbursement to the provider due to the failure of the provider to follow the procedures set forth in this program. [Emphasis added.]

Notwithstanding the language of paragraph GG cited above, there is, in effect, no appeal from the failure of the provider to follow the procedures because there is no leeway provided in the rules. A right of appeal without a remedy is no right at all. Certainly, a complex set of rules that sets out procedures must allow some reasonable means of correcting inadvertent omissions.

The Federal Guidelines in the Health Care Financing Administration's ("HCFA") State Medicaid Manual are reproduced to pages 6255-4 et seq. of the CCH Medicare and Medicaid Guide. On page 6255-5, ¶14,545 (copy attached in Addendum) it states as follows:

> The PAS [pre-admission screening] program need not provide for determinations in the case of a readmission to a NF [nursing facility] of an individual who, after being admitted to the NF, was transferred for care in a hospital.

At page 6255-8, ¶14,545 of said publication, it also states:

> HCFA notes that the statute makes preadmission screening requirements applicable to "new admissions." Thus a screening system which differentiates from admissions to an NF those which are "new" (as opposed, for example, to admissions of individuals who had been inpatients but were admitted to a hospital and are now being readmitted) would comply with the law.

Thus, Utah's Medicaid rules are more strict than the federal law requires and, in the case of a readmission, are a trap for the unwary. Even the Utah Department of Health has recognized that this is an unreasonable and unfair result. In its letter to Doxey-Hatch dated January 25, 1994 (Petitioner's Exhibit No. 1), the State said:

> The Patient Assessment Section would like to be able to make an exception in your case because human error was a factor and your past record has demonstrated compliance to our time frames, but our rules prohibit us from doing so. [Emphasis added.]

On page 3 of said letter and as a concluding paragraph, it states:

> Your facility, and particularly your Director of Nurses, has always been very efficient and conscientious in following our policies in the past, but our policies need to be applied fairly and consistently with all of our providers. [Emphasis added.]

Effective as of April 1, 1994, the DHCF adopted a new rule allowing each nursing care facility 30 patient days of reimbursement even when the rules have not been fully complied with for submitting Form 10A. This means that, in this case, Doxey-Hatch could have at least been compensated for 30 days of care. The mere fact that DHCF adopted this new rule demonstrates that it realized the unreasonableness and inequity of applying the harsh rules set forth in Part A of its Policy and Procedures Manual. Certainly, the adoption of such a new rule is evidence of the fact that the rules under which the reimbursement in this case was denied are unreasonable and irrational.

When this case is evaluated in accordance with the standards set forth in the Romero case, supra, i.e., whether the rules and

the decision are reasonable and rational, it is clear that a decision denying Medicaid reimbursement for medical care for the period September 6 through November 30, 1993 is unreasonable and irrational. Furthermore, the promulgation of the rule is an abuse of discretion and is reviewable by this Court under §§63-46(b)-16(4)(h)(i). Kent v. Department of Employment Security, 860 P.2d 984 (footnote 3 at 986), (Utah App. 1993).

C. The Decision to Deny Payment is Inconsistent with Prior Cases in Which Payment Has Been Allowed and is Arbitrary and Capricious.

Carolyn Reese, Manager of the Patient Assessment Section, described two cases in which health care providers were granted leeway from the time requirements of Form 10A. One case involved a situation where the care provider was told by the state Department of Family Services that Form 10A was not necessary and the other case involved a situation where a director of nursing died and it was not possible to submit the Form 10A at issue until the next day.

In the first case, an exception (forgiveness for not complying with the rules) was allowed because the state made a mistake in advising that Form 10A was not required. Apparently, it is okay to not comply with the rules if the state makes a mistake but not if a provider makes a mistake. However, there was apparently a third incident (T. 36), or perhaps it was the first incident referred to above since the record is not clear on this point, wherein a person went into a nursing home (date not stated), died in March, and the Form 10A was submitted in June. The claim was paid retroactively.

When asked where her authority was in the Rules for making such allowances, Ms. Reese testified (T. 43) that the authority is in R455-9-6-CC. That rule is as follows:

> The Section will make determinations via telephone daily from 8:00 a.m.-5:00 p.m., except weekends and holidays. The Section Manager may make appropriate administrative adjustments to section processing requirements to cover emergencies occurring during uncovered times.

Ms. Reese defined "uncovered times" as non-business hours when there are no staff available at the state offices.

Clearly, Ms. Reese had no authority under the cited provision above to grant administrative relief in any of the above-mentioned cases because there was no evidence that the problem was an emergency during "uncovered times." This is particularly true in light of R455-9-6-T.2 wherein it states that there will be no exceptions to the policy requiring Form 10A be presubmitted. She apparently simply felt that the circumstances justified relief but that the instant case does not warrant relief. She did not explain how the case at bar differed from the case involving the person that died in the nursing home in March and the Form 10A was not submitted until June except that there was some unexplained "rule making request." Coincidentally, the time frame in that case could have been as much as 120 days (March through June) whereas the case at hand involved 85 days. That case was paid but in the instant case payment was denied. Based on these facts, the decision in the case at hand is inconsistent with the prior case and the action of DHCF was inconsistent and arbitrary. Appellant is entitled to relief under Utah Code Ann. §63-46(b)-16(4)(h)(iii) and (iv).

D. The Rule Relied Upon by DHCF Does Not, In Fact, Require that a New Form 10A be Submitted.

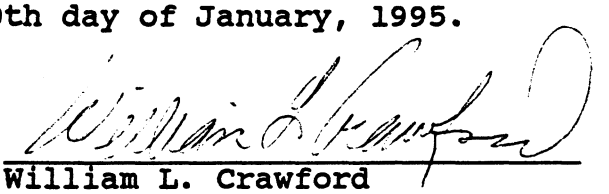
Rule 455-9-6-G is quoted in full above at page 5. As can be clearly seen, the rule states that preadmission authorization will not be required for a hospital admission when the applicant/-recipient returns to the original nursing care facility within less than three days of admission to a hospital. A reasonable reading of this rule is that Primary Children's Medical Center (the "hospital") did not have to do a preadmission authorization if the patient were to return to the nursing care facility (Doxey-Hatch) within three days of admission to the hospital. Since this case did not involve a "hospital admission," the rule doesn't even apply in this case. If this rule were to apply to a nursing home readmission, it would have said "Preadmission Authorization will not be required for a nursing care facility when the applicant/recipient returns to the original nursing care facility within less than three consecutive days of admission to a hospital." However, the way the rule is written, it is clear that "hospital" and "original nursing care facility" are two different facilities. There is, as a point of fact, no provision in Rule 455-9 that requires a new preadmission screening when a person is returning to a nursing home facility from a hospital. DHCF has simply put that erroneous interpretation on the rule. DHCF action in denying reimbursement is based on a rule that does not apply to the case at hand. Appellant is entitled to relief under Utah Code Ann. §63-46(b)-16(4)(d) and (h)(ii).

CONCLUSION

The facts demonstrate that this case is clearly distinguishable from the Romero case, supra, and that Appellant should be reimbursed for the care provided to Amber. The action of DHCF in denying payment is wrong because DHCF erroneously interpreted or applied the law and because the action is unreasonable, irrational, an abuse of discretion, contrary to its rules, contrary to prior practice and otherwise arbitrary or capricious. Utah Code Ann. §63-46(b)-16(4)(d) and (h)(i)-(iv).

The Department of Health should be required to pay Doxey-Hatch for Amber's care from September 6, 1993 through November 30, 1993. The Final Agency Order of DHCF should be reversed.

Respectfully submitted this 20th day of January, 1995.



William L. Crawford
Attorney for Petitioner-
Appellant Doxey-Hatch
Medical Center

MAILING CERTIFICATE

I hereby certify that I mailed a true and correct copy of the foregoing to Douglas W. Springmeyer, Assistant Attorney General, Attorney for Respondent-Appellee Utah Department of Health, Division of Health Care Financing, 288 North 1460 West, #429, P.O. Box 16700, Salt Lake City, Utah 84116-0700.

DATED this 23th day of January, 1995.

WILLIAM L. CRAWFORD
Attorney for Petitioner-
Appellant Doxey-Hatch
Medical Center

ADDENDUM

Utah Code Ann. §26-18-1

Utah Code Ann. §26-18-2.3

Utah Code Ann. §26-18-3

Utah Code Ann. §63-46(b)-16

Utah Administrative Rule R455 (Pages 1-22 only)

[Entire R455 is Respondent's Exh. 1]

CCH Medicare and Medicaid Guide, ¶14,545 (P. 6255-5)

CCH Medicare and Medicaid Guide, ¶14,545 (P. 6255-8)

CHAPTER 18
MEDICAL ASSISTANCE ACT

Sunset Act. — See Section 63-55-7 for the termination date of the Medical Assistance Act.

26-18-1. Short title.

This chapter shall be known and may be cited as the "Medical Assistance Act."

History: C. 1953, 26-18-1, enacted by L. 1981, ch. 126, § 17.

Repeals and Reenactments. — Laws 1981, ch. 126, § 1 repealed former §§ 26-18-1 to 26-18-4 (L. 1963, ch. 38, §§ 1 to 4; 1969, ch. 197, §§ 64, 65; 1971, ch. 53, § 1), relating to use of confidential information in research. Present §§ 26-18-1 to 26-18-10 were enacted

by § 17 of the act. For present provisions relating to confidential information, see Chapter 25 of this title.

26-18-2. Definitions.

As used in this chapter:

(1) "Applicant" means any person who requests assistance under the medical programs of the state.

(2) "Division" means the Division of Health Care Financing within the department, established under Section 26-18-2.1.

(3) "Client" means a person who the department has determined to be eligible for assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

(4) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.

(5) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients of medical or hospital assistance under state medical programs.

(6) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

History: C. 1953, 26-18-2, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 1.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, added present Subsections (2) and (3), designated former Subsections (2) and (3) as Subsections (5) and (6), and, in Subsection (6), substituted "has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10" for "the department has determined to be eligible for medical or hospital assistance under the medical programs of the state."

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

26-18-2.1. Division — Creation.

There is created, within the department, the Division of Health Care Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Utah Medical Assistance Program established in Section 26-18-10, in accordance with the provisions of this chapter and applicable federal law.

History: C. 1953, 26-18-2.1, enacted by L. 1988, ch. 21, § 2.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective on July 1, 1988.

26-18-2.2. Director — Appointment — Responsibilities.

The director of the division shall be appointed by the executive director of the department. The director of the division may employ other employees as necessary to implement the provisions of this chapter, and shall:

(1) administer the responsibilities of the division as set forth in this chapter;

(2) prepare and administer the division's budget; and

(3) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

History: C. 1953, 26-18-2.2, enacted by L. 1988, ch. 21, § 3.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective on July 1, 1988.

26-18-2.3. Division responsibilities — Emphasis — Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay. The division shall deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity appropriateness. The division shall place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

(2) The division shall implement and utilize cost-containment methods, where possible, which may include, but are not limited to:

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

(b) preadmission certification of nonemergency admissions;

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) coordination of benefits; and

(g) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.

(3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

History: C. 1953, 26-18-2.3, enacted by L. 1988, ch. 21, § 4.

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective July 1, 1988.

26-18-3. Administration of Medicaid program by department.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

(3) The department may, in its discretion, contract with the Department of Social Services or other qualified agencies for services in connection with the administration of the Medicaid program, including but not limited to the determination of the eligibility of individuals for the program, recovery of overpayments, and enforcement of fraud and abuse laws to the extent permitted by law and quality control services.

(4) The department may provide by rule for disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively shall not extend beyond termination from the program or recovery of claim reimbursements incorrectly paid.

History: C. 1953, 26-18-3, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 5.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, in Subsection (2) substituted "this chapter, the requirements of Title XIX, and applicable federal regulations" for "the requirements of Title XIX and with regulations adopted pursuant thereto by the federal agency" and made various minor phraseology and stylistic changes.

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

COLLATERAL REFERENCES

C.J.S. — 81 C.J.S. Social Security and Public Welfare § 126.

Key Numbers. — Social Security ⇐ 241.

26-18-3.5. Copayments by health service recipients, spouses, and parents.

The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.

History: C. 1953, 26-18-3.5, enacted by L. 1983, ch. 135, § 1.

COLLATERAL REFERENCES

Utah Law Review. — Utah Legislative Survey — 1983, 1984 Utah L. Rev. 115, 169.

26-18-4. Department standards for eligibility under Medicaid — Funds for abortions.

(1) The department may develop standards and administer policies relating to eligibility under the Medicaid program. An applicant receiving Medicaid assistance may be limited to particular types of care or services or to payment of part or all costs of care determined to be medically necessary.

(2) The department shall not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.

63-46b-16. Judicial review — Formal adjudicative proceedings.

(1) As provided by statute, the Supreme Court or the Court of Appeals has jurisdiction to review all final agency action resulting from formal adjudicative proceedings.

(2) (a) To seek judicial review of final agency action resulting from formal adjudicative proceedings, the petitioner shall file a petition for review of agency action with the appropriate appellate court in the form required by the appellate rules of the appropriate appellate court.

(b) The appellate rules of the appropriate appellate court shall govern all additional filings and proceedings in the appellate court.

(3) The contents, transmittal, and filing of the agency's record for judicial review of formal adjudicative proceedings are governed by the Utah Rules of Appellate Procedure, except that:

(a) all parties to the review proceedings may stipulate to shorten, summarize, or organize the record;

(b) the appellate court may tax the cost of preparing transcripts and copies for the record:

(i) against a party who unreasonably refuses to stipulate to shorten, summarize, or organize the record; or

(ii) according to any other provision of law.

(4) The appellate court shall grant relief only if, on the basis of the agency's record, it determines that a person seeking judicial review has been substantially prejudiced by any of the following:

(a) the agency action, or the statute or rule on which the agency action is based, is unconstitutional on its face or as applied;

(b) the agency has acted beyond the jurisdiction conferred by any statute;

(c) the agency has not decided all of the issues requiring resolution;

(d) the agency has erroneously interpreted or applied the law;

(e) the agency has engaged in an unlawful procedure or decision-making process, or has failed to follow prescribed procedure;

(f) the persons taking the agency action were illegally constituted as a decision-making body or were subject to disqualification;

(g) the agency action is based upon a determination of fact, made or implied by the agency, that is not supported by substantial evidence when viewed in light of the whole record before the court;

(h) the agency action is:

(i) an abuse of the discretion delegated to the agency by statute;

(ii) contrary to a rule of the agency;

(iii) contrary to the agency's prior practice, unless the agency justifies the inconsistency by giving facts and reasons that demonstrate a fair and rational basis for the inconsistency; or

(iv) otherwise arbitrary or capricious.

History: C. 1953, 63-46b-16, enacted by L. 1987, ch. 161, § 272; 1988, ch. 72, § 26.

Cross-References. — Review of proceedings before State Tax Commission, jurisdiction and standard, §§ 59-1-601, 59-1-610.

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) REQUIREMENTS FOR MENTAL ILLNESS (MI) OR MENTAL RETARDATION/RELATED CONDITIONS (MR)

R455 Health, Health Care Financing, Policy and Planning
R455-9 Nursing Facility Preadmission/Continued Stay Review and Level of Care Criteria
R455-9-1 Purpose

A. The purpose of the Preadmission and Continued Stay Review programs set forth herein is to enable the Division of Health Care Financing (hereafter "Division"):

1. to identify, statewide, the medical need of Title XIX applicants/recipients who are patients/residents of nursing care facilities or desire to be admitted to nursing care facilities in order to provide the appropriate type of care and services for illness or disability;

2. to assure quality of life while safeguarding against over or underutilization of services and costs; and

3. to ensure that certification for placement and reimbursement of nursing care facility services or for a State institution for acute care is given prior to placement; and

4. to ensure that persons with mental retardation/related conditions and/or mental illness seeking admission to or continued stay in nursing facilities are assessed for their need for active treatment services specific to these diagnoses.

B. Approval by the Division for nursing care for a Medicaid applicant/recipient is given only after professional analysis of alternative resources and settings of care appropriate to the total needs of the patient have been evaluated. Alternatives to nursing facility care may include, but are not necessarily limited to, the following community resources:

1. family;
2. homemaking services;
3. diet and nutrition;
4. socialization;
5. recreation;
6. physical therapy;
7. speech rehabilitation;
8. transportation;
9. economic assistance;
10. legal assistance;
11. counseling;
12. mental health services;
13. social support services;
14. housing assistance;
15. handicapped services;
16. services provided when applicable under Titles III, IV, VI, XVIII, and XX.

C. The decision to deny or grant preadmission or continued stay is an exercise of professional judgment, utilizing developed criteria applied by qualified professionals licensed in the healing arts.

D. The Division staff will be available during regular business hours to assist applicants/recipients and providers, either by telephone or personal appointment upon request, in complying with the requirements of this program. The nursing facility will make application for preadmission authorization by submitting a plan of care developed and approved by the attending physician and the director of nurses, in accordance with current physician orders and certified as deliverable by the facility administrator. The application when accepted and approved by the Patient Assessment Section will constitute an agreement for payment of care/services.

R455-9-2 Authority

A. The authority for the evaluation of each applicant's or recipient's need for admission and continued stay in the Skilled Nursing Facility and Intermediate Nursing Facility is defined under Federal Regulation 42 CFR 456.271 Medicaid Agency Review of Need for Admission (SNF), 42 CFR 456.371 Exploration of Alternative Services (ICF), 42 CFR 456.372 Medicaid Agency Review of Need for Admission (ICF), 42 CFR 456.331 Continued Stay Review Required (SNF), 42 CFR 456.431 Continued Stay Review Required (ICF), and the Omnibus Budget Reconciliation Act of 1987 (PL 100-203). The Division, in order to meet the requirements of the above regulations, has assigned the authority to assess the medical and social need, evaluate the level of care and assure appropriate placement to meet the applicant's or recipient's medical need to the Patient Assessment Section (hereafter "Section"), Bureau of Facility Review.

B. The Section has developed policies, procedures and medical criteria that will insure each applicant or recipient is assessed prior to placement and/or reimbursement, and to determine the duration of stay based upon continued review. These actions will safeguard against unnecessary or inappropriate use of Medicaid services and/or payment, while assuring the quality of services.

C. Under waiver authority granted to the Division effective January 1, 1982, these policies and procedures are designed to meet the intent of and are in lieu of all waiverable utilization review requirements of 42 CFR Part 456, Subpart D, and meet the utilization review requirements of 42 CFR Part 456, Subparts E, F, and G, Medical Care Evaluation Studies required under 42 CFR 456.341 - 345 are covered under policies and procedures for Surveillance and Utilization Review/Medical Care Evaluation Studies in the Bureau of Facility Review, Policy and Procedures Manual, Part C.

D. These policies and procedures also specify how physician certification and recertification requirements will be met in accordance with 42 CFR 456.160, 42 CFR 456.260, and 42 CFR 456.360.

E. The provisions of the Preadmission and Continued Stay Programs shall be governed by the Social Security Act, the laws of the State of Utah, under authority as granted by regulation as set forth in the 42 Code of Federal Regulation and Title XIX State Plan with which the Division ensures compliance.

R455-9-3 Availability

A. Preadmission Assessment Evaluation is required for recipients of Title XIX (Medicaid) and applicants for Title XIX (Medicaid) who are pending eligibility determination.

1. This includes any applicants or recipients already in a nursing facility who will be reclassified from a skilled care level funded by Medicare and/or Medicaid to Medicaid skilled or intermediate care.

2. Preadmission Assessment Evaluation is required for the following persons, if application for Title XIX (Medicaid) is anticipated within 90 days:

a. persons who are in a nursing facility and currently funded from other sources including, but not limited to, Medicare, Veterans Administration and private pay; and

b. persons who have been referred by the mental health center or have a civil commitment to the mental health system.

B. Failure by the provider to complete Preadmission requirements will result in noncoverage of nursing facility care retroactive to eligibility application.

C. The preadmission assessment is also available for any other individual who requests this service.

R455-9-4 Safeguarding of Client Information

A. The use or dissemination of any information concerning an applicant/recipient for any purpose not directly connected with the administration of the Preadmission and Continued Stay Program is prohibited except on written consent of the applicant/recipient, his attorney, or his responsible parent or guardian. (42 CFR 431.115)

B. Providers are responsible to ensure that information on patients who are not applicants for, or recipients of, Medicaid is not released without permission of the patient or guardian. The Division shall make available a form for this purpose.

R455-9-5 Free Choice of Providers

A. A recipient may request service from any certified nursing care facility provider subject to 42 CFR 431.51.

B. A recipient who believes that the recipient's freedom of choice of provider has been denied or impaired may request a fair hearing pursuant to 42 CFR 431.200.

C. A recipient's participation in medical assistance does not preclude the recipient's rights to seek and pay for services not covered by Medicaid.

R455-9-6 General Policy

A. The following policies apply to all Medicaid facilities and patients:

1. Physician Certification for inpatient services will be performed by a physician consultant for the Division. The state physician consultant will certify the patient's/resident's need for care/services based upon orders of the attending physician, the written plan of care, and state and federal level of care criteria as found in 42 CFR 405.127, 405.128, 405.128a and in R455-9-19.

B. Responsible Agencies

1. Authorization for placement or receiving an inter-facility transfer as related to SNF and ICF reimbursement for the Medicaid applicant/recipient, and IMR for the developmentally disabled/mentally retarded applicant/recipient, shall be the express authority of the Division. This does not preclude discharging patients/residents in accordance with certified discharge planning procedures.

2. Authorization for placement, transfer and discharge as related to the Utah State Hospital has been contracted with the State Division of Mental Health, Department of Social Services.

3. Authorization for conducting in nursing facilities (except ICFs/MR) the Preadmission Screening and Annual Resident Review (PASARR) as specified in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), Section 1919 (b) (3) (F), shall be the responsibility of the Department of Social Services, Division of Services to the Handicapped (for persons with mental retardation/related condition) and the Division of Mental Health (for those persons with mental illness) and is governed pursuant to a Memorandum of Understanding with the Department of Social Services.

C. The Division will maintain final authority for the determination of continuing care need and level of care for Title XIX patients/residents in nursing care facilities and in the Utah State Hospital.

D. The Division will ensure the initial and periodic comprehensive medical, social and psychological assessments by an interdisciplinary team of health professionals, and when it is determined to be appropriate, facilitate discharge planning. The applicant/recipient may elect to remain in the facility without reimbursement.

E. Discharge Planning:

1. The Weekly Consultive Committee will review each patient's/resident's discharge plan. When the status of the patient/resident is changed, the Committee will ensure that the patient/resident has a planned program of post discharge care that takes his/her care/service needs into account.

2. The Provider must designate a staff member for discharge planning. The discharge plan shall be included on the Patient Care Transmittal-Form 10/A.

3. When the Division initiates a discharge action, the Section social worker will contact the Provider and/or the Discharge Planning Designee to coordinate the implementation of the discharge plan to insure that post discharge needs are met.

4. However, when Title XIX (Medicaid) reimbursement is available for the patient/resident at a different level of care within the same facility, the discharge plan may be reevaluated, but it is not required that the Section social worker contact the Provider or the Discharge Planning Designee as required above.

F. Telephone Contact for Immediate Placement:

1. The Division will reimburse the nursing care facility for a patient/resident who has received immediate placement in that nursing care facility, without full assessment following telephone authorization to the nursing care facility by the Patient Assessment Section (Section). Reimbursement authorization by telephone is only effective for five working days unless the provider completes the patient care transmittal (Form 10/A) and mails it to the Section within the five working day period following admission. "Working days" is defined as all days except weekends and legal holidays.

2. For applicants/residents of nursing facilities (except ICFs/MR), results of the Identification (ID) Screening, as required by OBRA 1987, Section 1919 (e) (7), for mental retardation/related conditions and mental illness diagnoses, and the ID Screening document number, must be available when requesting telephone contact for immediate placement. If there is a positive finding of mental

retardation/related conditions and/or mental illness from the ID screening, the Preadmission Screening and Annual Resident Review (PASARR) Determination findings must be supplied through the Department of Social Services, Divisions of Services to the Handicapped and/or Mental Health.

a.) A copy of the ID Screening and if appropriate, the PASARR Determination must be submitted in accordance with R455-9-7.

3. The provider is responsible and required to complete the contact with the Section. The providers accept a patient/resident at their own risk and liability without obtaining preadmission approval by the Division.

G. Preadmission authorization will not be required for a hospital admission when the applicant/recipient returns to the original nursing care facility within less than three consecutive days (the actual day of discharge is not counted) of admission to the hospital. However, if the condition of a patient/resident returning to intermediate care or intermediate care for the mentally retarded in less than three-consecutive days (the actual day of discharge is not counted) may require skilled care, the nursing care facility must make immediate telephone contact with the Section.

H. Patients/Residents who leave the nursing care facility more than two consecutive days against medical advice, or who fail to return within two consecutive days after an authorized leave of absence, will be considered discharged from the Medicaid nursing care program and must complete all preadmission requirements before admission or readmission into the program. Providers are responsible to report all such instances.

I. Patients/residents who leave the nursing facility (except ICFs/MR) under G and H above, who are subject to the PASARR Determination process, must be reassessed under the PASARR Determination process prior to readmission.

J. Weekly Consultive Committee Meetings shall be held in order to process applications for which an individual health professional desires additional professional consultation. The Consultive Committee is chaired by the physician consultant and is comprised of additional health professionals as needed. Determinations made in the committee meetings shall be documented on the Committee Action Report Form.

K. Supplemental Onsite Review (SOR) will be performed by a health professional from the Division at the Division's discretion when a question of appropriateness of placement cannot be resolved by telephone or written documentation. The Division will also complete a Supplemental Onsite Review on written or telephone request of the Medicaid patient/resident, guardian or provider in the case of an adverse action.

L. Continued Stay Review:

1. The Division will provide at a minimum a 30, 90, and 180-day interim telephone review for determination of the need for continued nursing care and services. For administrative purposes, the 30, 90, and 180-day review of continued stay will be defined as completion during the calendar month in which it is due. An alternate schedule of more frequent review may be established based upon the professional evaluation of the patient's/resident's medical need for services.

2. Providers must make appropriate personnel and information reasonably accessible to the Division by telephone.

M. Changes in Patient Condition and/or Treatment Plan:

1. Providers must make contact with the Division by telephone or in writing when the needs of a patient/resident change so as to possibly require discharge or a different level of care.

2. For nursing facility applicants/residents (except ICFs/MR) subject to the PASARR Determination process, providers must make contact with the Division by telephone or in writing when there is a change in the status which could have an affect on the person's PASARR determination.

3. The Provider is expected to inform the Division of additional pertinent facts related to the care/service needs, diagnosis, medications, treatments, plan of care, etc., that may not have been known previous to the determination of medical need for admission and/or continued stay by the Division.

N. For skilled care patients the following applies:

1. The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission.

2. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note is written and signed by the physician at the time of each visit, and all orders are signed.

3. Subsequent to the 90th day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at 30-day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services, in which case the review must be in accordance with 405.1123(b). At no time may the alternate schedule exceed 60 days between visits.

4. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient:

   a. in the case of a Medicaid benefits recipient, the facility notifies the State Medicaid Agency of the change in schedule, including justification; and

   b. the utilization review committee or the medical review team (see 405.1121(d)) promptly reevaluates the patient's need for monthly physician visits as well as his or her continued need for skilled nursing facility services (see 405.1137(d)) (42 CFR 405.1123(b)).

5. The notification to the State Medicaid agency must be in writing and signed by the attending physician.

O. For intermediate patients, the following applies:

1. The physician must see the resident whenever necessary but at least once every 60 days unless the physician decides that this frequency is unnecessary and records the reasons for that decision. (42 CFR 442.346(b)).

2. The State Medicaid agency shall also be notified in writing by the attending physician of the reason that the patient/resident does not require the 60-day physician visit.

P. Every applicant for admission to a Medicaid certified nursing care facility and the Utah State Hospital will be certified by a physician and, if appropriate, reviewed by a psychiatrist.

Q. The Division will refer any willful misrepresentation of information to the Bureau of Program Review and the Office of Program Integrity for investigation and appropriate action.

R. The Division will automatically approve any Form 10/A that is not acted upon within 30 calendar days of receipt by the Division.

S. The Division will provide orientation and inservice to all nursing care providers, hospitals, related health agencies and the public upon request regarding the Preadmission and Continued Stay Review Programs.

T. Payment Authorization by the Division:

1. The Division will approve no payment for care/services to any nursing care facility prior to the date of receipt by the Patient Assessment Section of a valid contact as defined in R455-9-7 and completion of:

a. the assessment evaluation of each applicant/recipient;

b. all physician certification requirements; and

c. an ID Screening, and if appropriate, a PASARR Determination (except ICFs/MR) completed prior to admission; and

d. approval by the Patient Assessment Section.

2. There will be no exceptions to this policy. This means that Medicaid will not make payment for any care/services provided before the requirements of the preadmission program, as stated above, have been met.

3. If the provider does not choose to follow this policy, the provider will assume all liability for all incurred expenses for the care and services of the patient/resident. The provider will not bill the patient/resident or other responsible party for care/service not reimbursed by Medicaid due to the provider's failure to follow policy and procedures.

U. The following principles shall be used to determine responsibility for payment for nursing facility services whenever payment is sought from Medicaid by any party:

1. If eligibility and preadmission requirements and criteria have been met, Medicaid coverage consistent with the State plan will be provided.

2. If a provider submits a form 10A to the Section and he receives a denial notice on that 10A, the provider can resubmit additional or addendum documentation up to 60 calendar days from the date of receipt of the 10A by the Patient Assessment Section, as defined in R455-9-7, as a valid contact. If a provider fails to submit additional or addendum documentation to meet the specific criteria for denied placement of the patient within the 60 calendar day time frame, it will be understood that this placement denial will not be rescinded and the provider waives any and all rights to Medicaid reimbursement on this admission. A noted exception would be for any Medicaid reimbursement authorization previously granted by an approved telephone contact as defined in R455-9-6, F and R455-9-9.

3. If a provider has accepted a patient/resident who elects not to apply for or seek Medicaid coverage and payment, and the provider can demonstrate that the patient/resident or other responsible person has received adequate notice of preadmission requirements by having had the patient/resident or other responsible person read and complete the "Notice To Nursing Care Facility Patients, Residents, Applicants, and

Other Responsible Persons" prior to providing service, then the responsibility for payment shall be considered to rest with the person signing the "Notice" form. The provider should give a signed copy of the "Notice" to the responsible party at the time that admitting procedures are completed.

4. If a provider cannot demonstrate that adequate notice was given to a patient/resident or other responsible person of eligibility and preadmission requirements for Medicaid reimbursement, the responsibility for payment for care/services will not rest with the Medicaid program or the patient/resident, or other person not given adequate notice for any period in which the patient/resident met all eligibility requirement for Medicaid reimbursement and was in fact determined to be eligible for Medicaid services.

V. The provider is responsible and required to determine and certify the responsible party for reimbursement of care, and to notify the Division of any proposed change in reimbursement status. In order to meet the requirements of this policy, the Division shall make available a form for this purpose.

W. The Section will utilize professional consultants as necessary with expertise in medicine, psychiatry, psychology, physical therapy, social services, occupational therapy, recreational therapy and mental retardation.

X. The Section will refer medically noneligible or ineligible applicants/recipients to appropriate health related agencies when the professional assessment identifies such a need. Referrals may be made to other agencies and institutions serving or meeting needs associated with alcohol and drugs, crippled children, DD/MR, mental health, etc.

Y. The Section will utilize data to develop and improve services in the Department of Health to the provider, to the patient/resident, and the community through alternative resources.

Z. Patient Information:

1. The Section will assess the availability of alternative financial sources, such as veterans' benefits and voluntary family contributions, for each patient/resident and will apply for or solicit payment from each available source.

2. Patients, guardians and other persons responsible for placement in nursing facility care are required to provide information regarding the identity, and whereabouts of all living parents, siblings and/or children of the patient.

3. The providers must make available to the Division the information available in their files on the identity and whereabouts of all living parents, siblings and/or children of the patient.

AA. The Section will maintain records of all preadmission assessments, approvals, deferrals of action, referrals to other agencies, denials, changes in reimbursement status, follow-up reports and any other materials pertinent to the program up to a two-year period of time.

BB. The Section will monitor performance of Preadmission Program policies and procedures as performed by contract agencies and agencies with Memorandums of Understanding.

CC. The Section will make determinations via telephone daily from 8:00 a.m. - 5:00 p.m, except weekends and holidays. The Section Manager may make appropriate administrative adjustments to section processing requirements to cover emergencies occurring during uncovered times.

DD. The Form 10/A, a statement of patient condition, the ID Screening and the PASARR Determination (if appropriate) will constitute a transmittal from the provider to the Division of the care/services to be actually delivered to the applicant/recipient and subject to inspection of care review. Services given pursuant to a provider contract and Form 10/A must be documented to receive consideration during continued stay review, physician certification and physician recertification.

EE. Patients/residents identified for a change in level of care/service or identified for discharge shall continue reimbursement at the current level until 10-day advance written notice can be given prior to change in payment level.

FF. The applicant/recipient or patient/resident shall have the right of appeal of adverse decisions in accordance with the Utah Administrative Procedures Act (UAPA), Utah Code Ann. 63-46b-1 et seq.

GG. The provider may not appeal a preadmission or continued stay determination; but in accordance with Bureau of Facility Review, Policy and Procedures Manual may appeal a decision denying Medicaid reimbursement to the provider due to the failure of the provider to follow the procedures set forth in this program.

R455-9-7 Definition of Valid Contact

A. A valid contact is defined as documentation received by a telephone interview, a personal interview, written on the designated Patient Review form or other written referral which contains a minimum of the following information:

1. baseline demographic data:

   a. name of applicant/recipient;

   b. projected placement;

   c. date of transfer and/or admission to the facility (SNF, ICF, IMR);

   d. age of applicant/recipient in order to evaluate for Medicare eligibility;

   e. Medicaid eligibility status.

2. Diagnosis:

   a. a list of all established diagnoses;

   b. date of surgical procedures that precipitate need for care and/or date of traumatic incident such as fractured hip, CVA, acute MI, etc.;

   c. reason for acute care inpatient hospitalization within prior 90-day period, if applicable, and the care and services needed.

3. Medications and treatments currently ordered for client.

4. Medical and social history; summary of present medical, social and where appropriate, developmental findings.

5. The applicant's/recipient's current functional and mental status.

6. The rehabilitation potential and anticipated duration of stay.

7. Evaluation of alternative care resources and support services currently in use, previously used, and available through the community and family.

8. Name of the individual initiating the contact.

9. ID Screening for mental retardation/related conditions and/or mental illness (except ICFs/MR) completed prior to admission.

10. A PASARR determination, completed prior to admission, from the Department of Social Services, Divisions of Services to the Handicapped and/or Mental Health for applicants/residents with a positive finding for mental retardation/related condition and/or mental illness on the ID screening.

B. In order for a contact to be valid, it must be received and processed by a registered nurse, medical doctor or doctor of osteopathy authorized by the Bureau of Facility Review. No other person is authorized to receive or process the contact.

C. Final action on a valid contact can be deferred when it is determined that the care/services of an applicant/recipient is reimbursed by a third party payor and/or the applicant/recipient is not now eligible for Title XIX (Medicaid). The contact will be held on a pending status until:

1. the applicant/recipient has been approved for Title XIX (Medicaid) reimbursement when the contact will be approved as of the initial approval date if all criteria have been met;

2. the applicant/recipient has been denied (does not meet criteria);

3. the applicant/recipient does not pursue Title XIX (Medicaid) reimbursement within 120 days of initial contact.

4. the applicant/recipient has been referred to an alternative placement by the Section; or

5. the applicant/recipient is deceased.

R455-9-8 Definition of Invalid Contact

An invalid contact is one that does not meet all the requirements of a valid contact as defined in the preceding section (i.e. insufficient information to make a determination). An opinion may be given by the professional staff, but a final determination of approval/denial is not made. An example of an an invalid contact is when an interested person inquires about the program but does not make a valid contact at that time.

R455-9-9 Procedures for Processing Preadmission Reviews, Initial Contact

A. The initial contact for authorization of nursing home care placement can be generated from two sources:

1. a telephone and/or an in-person interview or;

2. the receipt of written documentation, e.g., a Form 10/A, that meets the requirements of a valid contact.

B. Authorization may be granted by a registered nurse and/or Qualified Mental Retardation Professional (Q.M.R.P.) assigned to the Bureau of Facility Review for an immediate placement need based upon a telephone and/or an in-person contact for one of the following conditions:

1. A hospital must discharge the applicant/recipient, or the applicant/recipient has utilized the full extent of acute care scope of benefits.

2. The patient's/resident's level of care has been changed by a fiscal intermediary for Medicare and/or the Medicare benefit days have been terminated and there is a need for continuing services reimbursed under Title XIX (Medicaid).

3. Protective services in the Department of Social Services has placed or is requesting to place a applicant/recipient for care.

4. A tragedy has occurred in the home (i.e. fire, flood), accompanied by injury to an applicant/recipient, or an accident leaves a dependent person in imminent danger and he/she requires immediate institutionalization.

5. The sudden illness or death of a family member who has been providing care to the applicant/recipient.

6. When a provider has terminated services either through an adverse certification action or closure of the facility, to assure a smooth transfer of patients/residents to an appropriate location to meet their medical and/or habilitation needs.

7. When the patient/resident presents a clear danger to himself/herself, other patients/residents or property in the present placement.

C. The provider should verify that approval has been given for the immediate placement to the specified facility prior to the admission of the patient/resident. The authorization for immediate placement will only be valid for a period not to exceed five working days. The provider must submit the complete assessment document (Form 10/A) postmarked within the approved five working day time frame to assure that reimbursement will be made from the date of admission.

D. If the provider fails to submit the Form 10/A within the five working day authorized period, payment will be terminated after five working days and will not be reinstated until receipt of the Form 10/A, and only if all preadmission criteria and conditions are met.

E. The telephone/in-person contact form is then logged, numbered and held in suspense to be matched with the required Form 10/A. When the provider submits the Form 10/A within the five day authorized time frame, the provider will be reimbursed from the initial contact approval date or date of admission, whichever is later.

R455-9-10 Authorizations

A. All admission and/or transfers to a nursing care facility (SNF, ICF or IMR) must be authorized prior to admission of the patient/resident. Placement will only be authorized upon receipt of the Form 10/A, unless the placement meets the conditions of immediate placement need as defined in the proceeding section. If the provider requests, a receipt will be given for the Form 10/A when hand delivered by a representative of the provider.

B. Authorization for admission is not transferable from one nursing care facility to another. The patient/resident must be processed through the preadmission program prior to each admission to each nursing care facility.

C. Retroactive authorization will not be given (prior to receipt of Form 10/A) for any admission and/or transfer into a nursing care facility from the applicant's/recipient's home, another nursing care facility or other location.

D. All ID Screenings must be completed prior to admission. In the case where the applicant/resident/recipient has had an ID Screening completed previously resulting in a negative finding for mental retardation/related conditions and/or mental illness, and there have been no changes affecting the previous ID Screening findings, a new ID Screening is not required.

E. All applicants/residents who are subject to the PASARR determination process must complete the PASARR determination prior to admission. Authorization from the PASARR determination is not transferable from one admission/facility to another.

R455-9-11 Processing

A. Upon receipt of the Form 10/A the document control analyst and/or the secretarial support staff will stamp the date of receipt on the form, enter document number and all applicable data from transmittal on computer. When applicable, the document control analyst and/or the secretarial support staff will also enter data from telephone contacts on computer, which will match with the Form 10/A by social security number. The Form 10/A is then referred to the Section's Registered Nurse and Physician (M.D. or D.O.) who will:

1. assess the applicant's/recipient's medical need for admission against written criteria;

2. determine the level of care required to meet the applicant's/recipient's medical need; and

3. authorize admission to the appropriate facility following the completion of the social assessment.

B. It is also the responsibility of the Registered Nurse and the Physician to deny placement when the applicant's/recipient's need does not meet the medical criteria, placement is not appropriate to meet the needs of the applicant/recipient, or if the patient's/resident's identified needs can be met by an appropriate and less costly alternative.

C. The assessment process is completed by the registered nurse in consultation with the physician assigned to the Section and with review by the Section's social worker as determined appropriate. Other health professionals are also consulted as appropriate to evaluate the applicant/recipient's need. The final determination is signed by the physician and the registered nurse.

D. Appropriate notice of decision will be mailed to the applicant/recipient, the attending physician, the provider, and when possible, the next of kin.

R455-9-12 Continued Stay Review

A. After the initial certification and authorization for admission and level of care determination has been made, the patient/resident is monitored for continued stay.

B. The document analyst, with back up secretarial support, is responsible to maintain the continued stay update files. Each approved patient/resident is reviewed by the professional staff at a minimum of 30, 90, and 180-days. For administrative purposes, the 30, 90, and 180-day review of continued stay will be defined as completion during the calendar month in which it is due. The registered nurse and/or physician may determine that an individual patient/resident will require a more frequent update due to the patient's/resident's condition and/or medical needs. They will notify the document control analyst of the alternate schedule for review, and she/he will adjust the call-up schedule accordingly.

C. Each week the document control analyst and/or the secretarial support staff will have the forms requiring update ready for review by the physician, the registered nurse and social worker. The registered nurse and/or social worker will telephone the facility and determine:

1. the progress that has been achieved toward goals;

2. if the care is appropriate or if additional services are needed;

3. other discharge indicators;

4. if there is a change in the level of care for each client; and

5. other pertinent data.

D. The registered nurse and social worker will review the findings of the telephone update with the physician to establish the need for continued placement and the level of care until the next assigned review date or discharge.

E. The patient's/resident's continued stay review is also integrated with the annual inspection of care review cycle. Each patient/resident identified during the review process as potentially not being cared for at an appropriate level or in an appropriate setting will be reassessed within 30 days by the Section to determine continued stay or evaluated for placement in an appropriate alternative.

F. The patient/resident may be referred to the Section's social worker for evaluation of social needs in relationship to the potential for admission or discharge. These patient/residents will be further monitored and certified for continued stay until discharge is completed or the patient's/resident's condition changes to indicate a continued need for services due to a medical need. Following the discharge of the patient, the social worker will complete a follow-up of the post discharge status.

G. The patient/resident, on completion of the 180-day review, will then be followed during the annual on-site inspection of care review cycle. However, the patient/resident may continue to be reviewed on a more frequent schedule as determined by the section to be necessary. Patients/residents identified during the annual inspection of care who are potential discharge candidates will be referred to the section for complete review and assessment by the Weekly Consultive Committee and the Section social worker for discharge to an appropriate alternative.

R455-9-13 Weekly Consultative Committee

A. The Section will refer to the Committee:

1. all applications that appear questionable and/or borderline;

2. all denial actions;

3. all applications that may be referred to other agencies for evaluation of alternative placement; and

4. all applicants/recipients or patients/residents where it appears to be feasible to meet their medical/health and/or habilitation needs through alternative services.

B. The Committee will meet at least on a weekly basis. The Committee will be chaired by the physician consultant and will consist of registered nurses, social workers, other health professional and patient representatives as needed.

C. The determinations of the Committee will be recorded on the Committee action report and will be retained with the Section's records.

R455-9-14 Determination by Patient Assessment Section

A. A determination of medical need and placement will be made within seven working days following receipt of a Form 10/A from a nursing care facility.

B. A determination of medical need and placement or deferral status must be completed and notification given to the appropriate individuals within 30 calendar days following receipt of the Patient Care Transmittal-Form 10/A.

C. The document control analyst and the secretarial support staff will maintain official files of all actions taken. The actions to be taken must be one of the following:

1. approval;

2. deferral;

3. denial; or

4. change in reimbursement status.

R455-9-15 Approval Action

A. When the recipient/applicant is approved for service, the Form 10/A is processed for entry into the payment mechanism.

B. Establishing the Effective and Expiration Dates of Form 10/A:

1. The effective date and expiration date for the period of service is established by staff assigned to the Section in accordance with established written policies and procedures. The effective date will be the date of receipt of the Form 10/A or the initial approval date of the telephone/in-person contact approval.

2. The expiration date is determined by the patients/resident's need for services to be provided as determined by the evaluation of medical need as applied to written criteria. The Division will notify the patient/resident of final determination of discontinuation of Medicaid reimbursement for nursing facility care/services.

C. The patient's/resident's level of care code and effective date are entered on the computer by staff assigned to the Section.

D. The document control analyst or the secretarial support staff copies the front page of the Form 10/A and distributes it to:

1. the provider; and

2. document control with the original transmittal sheet.

E. The review document and all attachments will be filed in the Form 10/A file for continued stay review by the Patient Assessment Unit.

R455-9-16 Deferral Action

A. Final determination of approval of an applicant/recipient may be deferred for any one or more of the following reasons:

1. The applicant/recipient has been referred to an appropriate alternative setting by the professional staff;

2. The applicant/recipient has not been approved for Medicaid (Title XIX) eligibility for reimbursement by the field service office serving the area in which the applicant/recipient resides;

3. The applicant/recipient is currently being reimbursed by a third party payor.

B. At the time of deferral action the application will be put on inactive status. The application will be reactivated if a written or telephone request is received within 10 days following notice to the applicant/recipient of the deferral action.

C. After 10 days, the applicant/recipient may be required to supply the Division with current and/or additional documentation of medical status/need in order to reactivate the application for admission.

D. A hearing will not be granted for a deferral action. However, the applicant/recipient may request a final determination of acceptance or denial in lieu of continued deferral.

R455-9-17 Denial Action:

A. The Section will deny admission or continued stay to all applicants/recipients or patients/residents who do not meet the medical criteria for admission/continued stay in a nursing care facility, or if the applicant's/recipient's medical need can be met by other available community and family resources.

B. When an applicant/recipient or patient/resident has been denied, the Section will send written notification to the nursing care facility administrator, the attending physician, the applicant/recipient, and if possible, the next of kin or sponsor in accordance with 42 CFR Part 431, Subpart D and Subpart E. Notice will be given no later than three working days after the decision is made, and for Medicaid patients, notice will be given at least 10 days in advance of the effective date of the action.

R455-9-18 Change in Reimbursement Status of Patient/Resident

The Section may determine that the medical needs of the patient/resident requires a different level of care/services than when the current or initial authorization was given. When this determination is made, the Section will send written notification to the nursing care facility administrator, the attending physician, the recipient, and if possible, the next of kin or sponsor in accordance with 42 CFR Part 431, Subpart D and Subpart E. Notice will be given no later than three working days after the decision is made, and for Medicaid patients, notice will be given at least 10 days in advance of the effective date of the action.

R455-9-19 Physician Certification/Recertification

A. The physician consultant will certify the need for inpatient services at the time the determination is made of the patient's/resident's level of care. The physician consultant will recertify the patient's/resident's continued need for inpatient nursing facility care/services at the determined level of care at least every 60 days after certification.

B. All patients meeting preadmission and continued stay requirements shall be deemed certifiable to the approved level of care by the physician consultant. The review schedule for continued stay review and the physician consultant's participation in that process shall be sufficient basis for certification. The physician will recertify a list of all patients/residents to the level of care approved by the preadmission assessment using the following statement:

"I certify that inpatient services are necessary for the next 60 days and the plan of care has been reviewed and approved for this patient."

C. No additional documentation shall be required. This procedure is intended to meet all Federal certification and recertification requirements.

D. All certification records shall be maintained by the Division.

E. With the assumption of the certification and recertification requirements, the State has no intent to assume the practice of medicine or to supersede the care requirements of the attending physician. The patient's/resident's attending physician continues to have the responsibility to meet the patient's/resident's needs and to assess the progress the patient/resident has achieved on a regular basis.

F. Patients/residents who are out of the facility less than 72 hours are not considered as a discharge and do not require a subsequent new certification for admission to the facility.

R455-9-20 Provider Responsibilities of Notice to the State Medicaid Agency

A. The provider is responsible to notify the Division of any change in the patient's/resident's condition or status, a determination by the attending physician of an alternate schedule for physician visits, and/or any other pertinent data affecting the patient's/resident's need for nursing facility care/services.

B. The provider may telephone the Patient Assessment Section for a change in the patient's/resident's condition and/or the need for care/services.

C. If the attending physician determines that the patient's/resident's needs can be met with an alternate schedule, the Provider must submit to the Section, the justification and/or reasons from the attending physician for the alternate schedule. This may be a copy of the attending physician's order or progress note.

PREADMISSION/CONTINUED STAY REVIEW
LEVEL OF CARE CRITERIA

R455-9-21 Preadmission/Continued Stay Review and Level of Care Criteria

A. The attached criteria requires that the Patient Assessment Section receive and approve the specific level of care before any Medicaid coverage can be authorized. The authorization for care is based upon the applicant's/recipient's severity of illness, intensity of service needed, anticipated outcome, and setting for service.

B. The Patient Assessment Section will utilize the Preadmission/Continued Stay Inpatient Care Transmittal-Form 10/A as the prior authorization document. Completion of this form is contingent on information obtained from the certification of need for inpatient care, medical, psychological and social evaluations, exploration of alternative services and individual written plan of care, which are required before admission to the nursing care facility as specified in Title 42 of the Code of Federal Regulations Part 456, Subparts E and F.

C. The provider may submit copies of the comprehensive medical evaluation, nursing care assessment, social services evaluation and interdisciplinary plan of care in lieu of filling out the sections of the Form 10/A which document the medical review, nursing assessment and social services evaluation. The provider is required to submit the Preadmission/Continued Stay Inpatient Care Transmittal and the Patient/Resident Release of Information Form with all required documentation whenever there is a request for Medicaid reimbursement authorization.

D. The Patient Assessment Section may require additional documentation to complete the preadmission assessment process.

R455-9-22 Level of Care Definitions

A. "Active Treatment" means training and habilitation services defined in Title 42 Code of Federal Regulations, Section 435.1009 and Section 483.440, which are intended to aid the individual in intellectual, sensorimotor, and emotional development. These regulations are hereby adopted by reference.

1. Active Treatment under this definition is applicable only to individuals with a diagnosis of mental retardation or developmental disability residing in ICFs/MR.

cilities (NFs) and the states. Some of these requirements are:

1. Medicaid NFs must not admit, on or after January 1, 1989, any new resident who has:

- Mental illness (MI), unless the state mental health authority has determined, based on an independent evaluation performed by a person or entity other than the state mental health authority, prior to admission, that the individual requires the level of services provided by a NF and, if so, whether the individual requires specialized services for MI; or

- Mental retardation (MR), unless the state MR or developmental disability authority has determined prior to admission that the individual requires the level of services provided by a NF, and, if so, whether the individual requires specialized services for MR. (See § 1919(b)(3)(F) of the Act.)

A mentally ill individual is redefined under OBRA 1990 as one who has a serious mental illness as defined by the Secretary in consultation with the National Institute of Mental Health and does not have a primary diagnosis of dementia or a diagnosis of dementia and a primary diagnosis that is not a serious mental illness.

2. Approval of a state's Medicaid plan requires that:

- The state has in effect, as of January 1, 1989, a preadmission screening (PAS) program for making determinations (using criteria developed by the Secretary) described in § 1919(b)(3)(F) of the Act for individuals with MI or MR.

The PAS program need not provide for determinations in the case of the readmission to a NF of an individual who, after being admitted to the NF, was transferred for care in a hospital. An interfacility transfer from one NF to another NF, with or without an intervening hospital stay, is not subject to PAS.

A PAS is not to be performed for an individual admitted to a NF directly from a hospital after receiving acute inpatient care at the hospital if the individual requires NF services for the condition for which care was received in the hospital and the attending physician certifies, before admission to the NF, that the individual is likely to require a NF stay of less than 30 days.

- For each NF resident who has MI, the state mental health authority must review and determine (using criteria developed by the Secretary), based on an independent physical and mental examination performed by a person or entity other than the state mental health authority, whether the resident requires:

—The level of services provided by a NF or by an inpatient psychiatric hospital for individuals under age 21 or by an institution for mental diseases for individuals 65 years of age or older, and

—Specialized services for MI. (See § 1919(e)(7)(B)(i) of the Act.)

- For each NF resident who has MR, the state MR authoritiy must review and determine (using criteria developed by the Secretary) whether the resident requires:

—The level of services provided by a NF or the level of services of an intermediate care facility for the mentally retarded (ICF/MR), and

—Specialized services for MR. (See § 1919(e)(7)(B)(ii) of the Act.)

- The state must have performed, by April 1, 1990, initial annual resident reviews (ARRs) on all residents with MI or MR who were not subject to PAS (i.e., residents who entered the NF prior to January 1, 1989). (See § 1919(e)(7)(B)(iii)(III) of the Act.)

- The state must have in effect, as of April 1, 1990, an ARR program for reviewing all residents with MI or MR, regardless of whether they were initially screened under the PAS or initial ARR requirements. The state must conduct such reviews at least annually, or more frequently if there is a change in the resident's condition. (See § 1919(e)(7)(B)(iii)(I-II) of the Act.)

3. Reimbursement for PASARR activities:

- Is available at the 75 percent rate for expenditures found necessary by the Secretary for the proper and efficient administration of the state plan which are directly attributable to PAS and ARR activities conducted by the state under § 1919(e)(7) of the Act. Only direct costs allocable to PASARR are eligible for reimbursement at the enhanced FFP rate. Costs not directly allocable to PASARR are matched at the 50 percent rate. Such costs are usually indirect costs, including statewide and departmentwide costs.

- Is not available under § 1903(a) of the Act for NF services furnished to an individual for whom a PAS or ARR determination is required under § 1919(b)(3)(F) or § 1919(e)(7)(A) and (B) of the Act but for whom the determination is not made.

- Except as otherwise provided in an approved alternative disposition plan (ADP), is not available under § 1903(a) of the Act for NF services furnished to an individual who does not require the level of services provided by a NF (except for long term mentally ill or mentally retarded residents not requiring NF services but needing specialized serices who elect to remain in the NF).

who have MI or MR, all individuals applying to or residing in a Medicaid-certified NF should be screened in some fashion to determine if they have MI or MR regardless of the "known diagnosis."

HCFA notes that the statute makes preadmission screening requirements applicable to "new admissions." Thus a screening system which differentiates from admissions to an NF those which are "new" (as opposed, for example, to admissions of individuals who had been inpatients but were admitted to a hospital and are now being readmitted) would comply with the law.

HCFA has also been advised that the statute provides no basis for limiting preadmission screening or annual reviews by method of payment. Therefore, all individuals, regardless of whether they are private payers, Medicare beneficiaries, or Medicaid-eligible individuals, must be screened if they reside in or apply to a Medicaid-certified NF. These requirements do not apply to a facility participating solely in Medicare as a skilled nursing facility (SNF).

Because an IMD can be a NF, and all NFs are subject to the PASARR requirements, HCFA has been advised that NFs which participate in Medicaid as IMDs are subject to PASARR. HCFA notes that the definition of a NF set forth in § 1919(a) appears to be somewhat inconsistent with the definition of an IMD in that it states that a NF is an institution that "is not primarily for the care and treatment of mental diseases." HCFA believes, however, that the best reading of these two definitions is that a NF can be both a NF and an IMD. In such situations, the NF maintains its status as a certified NF, but the IMD classification applies. That is, when NFs provide IMD services for persons over 65 years of age or inpatient psychiatric services for individuals under 21, HCFA considers these facilities in the context of these benefits even though they meet NF requirements. For individuals aged 22 to 64, residence in an IMD precludes them from receiving any Medicaid benefits.

The PASARR requirements do not currently apply to swing beds because the existing swing bed regulations at 42 CFR 482.66(b) list those SNF requirements which swing beds must meet and would need to be revised to include PASARR requirements before they would be applicable. When HCFA revises these regulations, it anticipates requiring that PASARR apply to swing beds.

The statutory PASARR requirements make no specific reference to time frames within which the state mental health and mental retardation authorities must perform the required screenings and make the required determinations. HCFA intends to specify in forthcoming regulations that determinations must be made in a timely manner. HCFA believes that timely action is necessary in order to prevent unnecessary extensions of inpatient hospital stays or inappropriate delays in providing needed services to individuals with MI or MR while they await screening by the state.

To the greatest degree possible, a state should interface the PASARR process with other existing or future NF preadmission screening and resident assessment procedures. For example, data compiled as part of the preadmission screening (PAS), which, by definition, takes place prior to admission, may be used in conducting the initial assessment which must be performed on a new resident. Currently, these initial assessments must be performed no later than 14 days after the date of admission. As of October 1, 1990, they will have to be performed within the first four days after the date of admission. Similarly, the results of the routine annual resident assessment (or more frequent assessments which are precipitated by a change in the resident's status) may be used for purposes of identifying residents with MI or MR who must be referred to the state mental health or mental retardation authorities for the annual resident reviews (ARRs).

Residents who are subject to annual reviews fall into two groups: (1) all who were previously identified as having MI or MR through preadmission screening or initial reviews and who were, for one reason or another, permitted to enter or remain in a nursing facility; and (2) any other residents who are later discovered to have MI or MR. If a resident, who was either not identified as having MI or MR (and therefore was not referred for further screening) or was found not to have MI or MR as a result of the preadmission screening or initial resident review, is later found to have a previously undiagnosed or a new condition of MR or MI, that individual should be referred to the state authorities for screening and a determination.

HCFA envisions that discovery of "new" cases of MR or MI will occur in one of two ways. Unlike MR which has a constant nature, MI frequently has an episodic character. Some NF residents may develop MI while in the NF. Development of a new condition or a significant worsening of an existing condition would be a change in the resident's health status which should trigger a reassessment under current regulations (483.20(b)(4)(iv)). HCFA also anticipates that once the uniform data set is in use for routine annual resident assessments (as required by OBRA '87 as of October 1, 1990), some conditions which had previously been inadequately or incorrectly diagnosed may be detected.

The facility should immediately refer "new" cases of MR or MI to the state mental health or mental retardation authorities. At the state's option, the actual screening may be postponed until the next scheduled resident review session at that facility. If